SGIMBC
The Society of General Internal Medicine of BC

SOCIETY OF GENERAL INTERNAL MEDICINE SPECIALISTS OF BRITISH COLUMBIA

MINUTES OF THE 2022 ANNUAL GENERAL MEETING *DRAFT*

FEBRUARY 4TH, 2023

Members Present: 35 via Zoom, 10 in person
Executive: Shavinder Gill (President), Paul Hertz (Treasurer), Jennifer Grace (Past President), Ritu Kumar, Denise Jaworsky, Samantha Segal (Interior Health Representative), Barry Kassen, Jasdeep Saluja. *Absent: Casey Chan*
Staff: Shannon Harrison (Executive Assistant)

The order of the agenda was varied throughout the meeting. Items are presented in these minutes in the order in which they appear in the agenda.

1. **LAND ACKNOWLEDGEMENT**
   It was acknowledged that members of the Society of General Internal Medicine Specialists of BC are grateful to live, work, and be in relation with people from across many traditional and unceded territories, covering all regions of British Columbia. We are honored to live on this land and are committed to reconciliation, decolonization, and building relationships in all our communities.

2. CALL TO ORDER
Shavinder Gill, President, called the Hybrid 2022 Annual General Meeting (AGM) of the Society of General Internal Medicine Specialists of British Columbia (SGIM) to order at 8:35 a.m.

3. **INTRODUCTIONS**
Members introduced themselves, their place of work and their opinion about long term GIM goals.
Discussion ensued on:

- Recognition of the importance/value of GIM work and our place in Medicine as a whole
- Understanding of GIM by colleagues, the public and the governing bodies
- Protect GIM within greater medical community as more sub-specialists enter hospitals and community
- Integrity of fee codes that accurately reflect both clinical and academic work
- Increase in payments for outpatient consultation and especially follow-up in community.
- There is massive potential in outpatient world.
- Recognizing high cost difference between outpatient and hospital-based care (i.e. overhead)
- Compensation for discussing patient cases with other sub-specialists
- Become leaders in healthcare innovation/revision with unique position within healthcare
- Emphasize GIM cost effectiveness and value for government bodies. We need to be more proactive and have a voice commensurate to the size of our speciality (similar to the GPSC)
- Fund study/pilot project on GIM practice to show government value (i.e. having all consults seen by GIM prior to being seen by sub-specialists)
- Recognition of the scarcity of GPs and the resulting primary care work that gets shunted to us (“Can you be my GP?”)

4. MINUTES OF THE 2021 ANNUAL GENERAL MEETING (December 4th, 2021)
It was MOVED and SECONDED
That the Society of General Internal Medicine Specialists of British Columbia approves the minutes of the December 4th, 2021 Annual General Meeting, as presented.

CARRIED

5. FINANCIAL UPDATE
5.1. Changed banking institutions as part of permanent shift to fully manage SGIM financial accounting.
5.2. Moved most of the $300K cash balance from 2021 into relatively short-term fixed income investments, mostly GICs, that are available for capital projects, etc.
5.3. Held approximately 1 year of operating budget in cash ($50K).
5.4. Highlighted comparison of revenues and expenses from last AGM (late 2021) to now (early 2023).
5.4.1. Income primarily from membership dues, minor amount from interest.
5.4.2. Starting in 2022, Executive Members compensated for time at DoBC Sessional rates.

Discussion ensued on:

- Renegotiating/removing banking fee charges.

5.5. Fee Code Updates Part 1

5.5.1. Two GIM Retroactive Payments: December 14, 2021 (retroactive Apr 2019-Mar 2020) and November 15, 2022 (retroactive Apr 2020-Mar 2021)

5.5.2. One GIM Fee Code Increase, September 29, 2022 (retroactive to April 2021).

5.5.3. SGIMBC Requests Submitted to MSP (no response yet)

5.5.3.1. Complex follow ups: 32308 Remove 10-day limit (post-admission) and 32307 Remove 6-month limit (post-consult)

5.5.3.2. Reinstatement of 2 system consult fee (32312)

5.5.4. SGIMBC Executive Considerations

5.5.4.1. Adjusting diagnosis for 311: If move forward with this MSP automatically changes fee code to provisional status (allows MSP to adjust, modify, reduce at their discretion).
Every fee code when created or changed becomes provisional for a period of time. MSP studies it and then has the authority to adjust at their discretion
Discussion ensued on:

- Large size of 311 reflects the increasing complexity of patient population
- Reflects what GIM physicians actually do, and the success of recruitment/retention
- GIM challenged by MSP/colleagues for 311 being high percentage of consults (over ~55%)

5.5.4.2. Creation of complex limited consult code

5.5.4.2.1. Limited consult code 32212 is valued less than the follow up code 32307.

5.5.4.2.2. Value of the limited consult code caps the value of the follow up code.

5.5.4.2.3. Potentially create a complex limited consult code which would have higher value.

5.5.5. Disparity as presented at CSIM conference.

5.5.5.1. Looked at inter-provincial and intra-provincial, three scenarios where billings were different.

5.5.5.2. Painted BC in reasonable light.

5.5.5.3. Spoke to GIM billing differently per situation.

5.5.6. New PMA: Approved Nov 2022, $708M per year available in new funding. General fee increases between 1-3%. $70M for fixed disparity, $15M for cSBC.

5.5.6.1. Arbitrator selected on Feb 1, 2023 to decide disparity funding. Same person as used previously.

5.5.6.2. BCP increase, inclusion of hospital-based fees

5.5.6.3. MOCAP increase (10%) and Sessional Rate increases (3.5% and 1%)

5.5.6.4. Increase available for disparity

5.5.6.5. Improved retirement savings (~$1000/yr) and parental benefits (~$30%)

5.5.6.6. Non-monetary benefits:

5.5.6.6.1. Maintenance of temporary COVID fees including virtual.

5.5.6.6.2. Working group looking to address: administrative burden, non-MSP eligible patients (BC residents), re-referrals, gender disparity and other DEI initiatives.
Discussion ensued on:

- Potentially removing option for telehealth and negative impacts on Indigenous communities.
- GIM to advocate for telehealth to remain.

5.5.7. Definition of an “active issue” in the eyes of MSP and Billing Integrity.

5.5.7.1. Up to individual physicians to read and interpret the fee guide.

5.5.7.2. In order to bill issues under 311, each issue should be individually identified in the consult and should have an assessment and plan for each issue.

5.5.7.3. Provisional diagnoses are fine (no confirmed diagnosis to bill) but multiple diagnosis for the same symptom are not allowed, unless they all exist.

5.5.7.4. In follow-up notes each individual issue should be outlined with an assessment and plan.

5.5.7.5. Writing something as ‘stable’ or ‘resolved’ does not count. Should have a simple follow up.

It was MOVED and SECONDED

That the Society of General Internal Medicine Specialists of British Columbia accepts the financial reports for the year ended February 1, 2023 as presented.

CARRIED

6. HISTORY OF CRIM/SGIMBC

6.1. **Mission Statement**: "General Internal Medicine (GIM) is a specialty uniquely positioned to deal with complex, multi system disease, provide high-value care to both the patient and the healthcare system"

6.2. **Motto**: "Physicians dedicated to evidence-based and comprehensive care" "Specialists for the adults" "Physician believing in holistic care"

Discussion ensued on:

- An error in the mission statement - GIM does not provide high-value *care* to the healthcare system.
- Need for updated and more accurate mission statement and motto.
- 'Specialists for complex patients" suggested as motto.
- Will discuss further in 2023.

7. **FEE CODES**

7.1. How are fee codes created?

7.1.1. Need – Example is the repeated limited consult code for 00311 for complex patients.

7.1.2. Budget & Money – Fee code budget and then funding/money must be identified/secured.

7.1.3. Application – Send application to MSP. If MSP accepts then DoBC Tariff Committee reviews. If Tariff Committee accepts then the application goes back to MSP for final approval.

7.2. Provisional Status

7.2.1. Any new or changed fee code has provisional status for 18-24 months where MSP can reduce or remove at their discretion.

7.2.2. If MSP finds over usage then extends the provisional status to allow for further review.

7.2.3. If MSP finds over usage then the Section must produce the funding/money required to make up the shortfall.

7.2.4. If the Section cannot produce the funding/money, MSP could reduce or remove the fee code completely. (Ex. GIM 2 system consult fee code).

7.3. Changing Fee Codes

7.3.1. Fee codes can only be permanently increased when have permanent status.

7.3.2. Adding or changing diagnoses moves a fee code into provisional status.

7.3.3. MSP has ultimate authority over fee codes.

Discussion ensued on:

- Risks related to modifying fee code diagnoses
- List of 30 GIM fee codes finalized over 6 months by Danny Meyers (past president) working with MSP.
  - MSP would not accept certain codes and diagnoses (ex. Obesity)
  - MSP insisted GIM represent most of the internal medicine sub specialty diagnoses.
  - DoBC identified 'creeping' where the increase in 311 fee code is not because of increasing complexity but due to physicians utilizing it more because of its higher renumeration.
  - 311 was created without constraints (ex. not time based) to provide better billing opportunities for GIM physicians.
- With the information provided about the 311 fee code, suggestion to add to/bolster 32210.

7.4. Fee Code History

7.4.1. Only section whose *major* consultation fee code (2-system fee code) was removed.

7.4.2. Among few sections whose follow-up fee codes were reduced more than once.

7.4.2.1. 32308 reduced twice.

7.4.2.2. 32307 reduced.

7.4.3. Only section where all fee codes but one (311) were provisional for far longer than 18 months.

7.4.3.1. MSP informed GIM at the end of 2020 that 32110 would become permanent, but it did not.

7.4.4. Consult fee used to be $119, now is $202 for single system consult and $285 for 3 system consult.

7.4.5. Follow up fee code (hospital) used to be $19 and now is $50 for single system and $67 for 3 system consults.

7.4.6. Follow up fee code (office) was $39 and is now $80 for single system and about $99 for 3 system consults.

7.5. Fee Code Reduction

7.5.1. Background – Funds for 2-system and other follow up fee codes came from finite LMA (Labour Market Adjustment) funding in 2011. Went overbudget so MSP removed the 2-system fee code and reduced the other follow up fee codes.

7.5.2. Learnings – Instead of agreeing to remove a fee code should prioritize reducing its budget to maintain long term code access.

7.5.3. MSP Perspective – Believes majority of GIM patients are 2 diagnostic codes. If they reinstated the 2-system fee code then it will become overused.

Discussion ensued on:

- Advantage of large 311 being when there's a % increase for general codes
- Perception of 311 as being too large by other specialists and MSP
- Perception that 311 isn't being used properly
- Removal of supposedly lesser used codes being detrimental to many GIM physicians
- Coordinating care and the critical care burden in remote locations not captured in fee codes
- SGIMBC social accountability - need to help address disparities in rural/remote settings with different healthcare challenges due to minimal resources
  - Create subcommittee to focus on advocating for better remuneration for rural colleagues
  - DoBC has rural/remote committee
  - Family Doctors now have time-based set rate applied to non-clinical interaction time, equal to sessional payment.

7.6. Fee Code Options

7.6.1. Time Based Fee Codes: MSP talking about implementing time-base fee codes for GIM. If they are implemented, will be impossible to reverse.

7.6.2. Billing IM Fee Codes: If GIM physicians are billing IM fee codes SGIMBC may need to add funds to IM fee codes rather than GIM fee codes in the future.

7.6.3. Single GIM Fee Code: Idea to replace 2 or 3 system fee codes with a single 'simplified' fee code system.

Discussion ensued on:

- MSP decisions are almost impossible to change or reverse in the future
- Logistics of how MSP would track/audit time-based fee codes using schedule and patient notes
- Time based-fee codes wouldn't work universally for GIM
- Reminder to all members to use GIM fee codes for GIM work
- As a non-procedural specialty, GIM needs different consultation fee codes
- GIM are doctors of complexity that is not accurately reflected in fee codes
- Complex fee codes are important for GIM physicians
- Idea to create an 'add-on modifier' with additional diagnostic codes.
  Ex. See a patient for hypertension (32210) but also see them for obesity and sleep apnea. Could bill 'add-on modifier' code of $10-20 which could apply to 311 or 32210. Possible work around making codes provisional when changing them. *SGIMBC to ask MSP about this idea.

7.7. Fee Code Good News

7.7.1. SGIMBC requested MSP (via Tariff Committee) make all GIM codes permanent and also waive the over budget funds.

7.7.1.1. All fee codes now permanent except 32207 and its equivalent TeleHealth fee code, and 32307/32308 as they are LMA fee codes.

7.7.1.2. 32307/32308 are over budget. SGIMBC waiting for response from MSP on waiving over-usage. MSP stated they would not reduce these fee codes even though they are not permanent.

7.7.2. SGIMBC provided DoBC with data for 2-system fee code use that proved MSP's assumption is false. DoBC also agreed that MSP delaying fee code decision for 3.5 yrs was too long. DoBC will go back to MSP to advocate reinstatement for 2-system fee code.

7.7.3. At March Tariff Committee SGIMBC will request separating GIM fee codes from IM fee codes.

7.8. Financial Disparity

7.8.1. Presentation at CSIM in 2022. Possibility that CSIM will create a national economic committee to address disparity.

8. SGIMBC UPDATES

8.1. SGIMBC website is updated regularly with fee code and member related new.

8.2. Some GIM physicians still not members of SGIMBC. Request to encourage colleagues to join and get involved. Join through Doctors of BC registration.

8.3. 2022 Membership Survey indicated the majority wanted to educate colleagues and general public about GIM.

8.3.1. One idea to create and print a document to be distributed to all doctor's offices. Long term/low cost.

8.3.2. Executive looking to speak with marketing/PR companies to develop focused, actionable plan.

8.4. Priority Pillars: Suggestion to focus on 4 priorities as a society.

8.4.1. Enhancing GIM – Protecting fee codes and provincial GIM practice. Protecting membership list who can access GIM fee codes.

8.4.2. Creating 2 Committees – Administrative Committee (support members getting admin positions within BC Health Authorities, DoBC has funding available) and another Committee (support members getting positions within DoBC/cSBC committees).

8.4.3. Liaison with other lower paid medical/surgical specialties. Create coalition/group with aligned priorities.

8.4.4. Liaison with CSIM, ACP and other GIM societies

Discussion ensued on:

- JSE has rural alternate available. Six times per year. Due Feb 7th.
- Adding UBC GIM and Community Internal Medicine to 4th pillar to leverage the provincial scope of university to support members more broadly. Exciting new opportunities in Fraser.

9. NEGOTIATIONS UPDATE

Noted in Section 5.5.6

10. **GENDER DISPARITIES IN GIM *share presentation?**

Denise Jaworsky presented data sourced from MSP billings 2019-2020 fiscal year, provided by DoBC from the MSP claims file. Includes only data for physicians billing over $150K/year.

10.1. GIM physicians in BC, annual total fee for service payments, comparing male to female

10.1.1. Average for women was approximately $100K less annually

10.1.2. Average number of days worked by women were less (9%)

10.1.3. Difference in fee for service payments was 25%

10.2. GIM 75%, compared to other specialties

10.2.1. some had even larger gap (Critical Care 60%), some had almost no gap (Radiology 90%)

10.3. In relation to the argument that the disparity relates to fewer hours worked.

10.3.1. Reviewed time-based after-hours codes.

10.3.2. Per individual physician, women slightly more units of call out

10.3.3. Women billing more units of continuing care per call out

10.4. Service types as percentage of total billings

10.4.1. Consultation, LMA codes are top for both men and women

10.4.2. Electrodiagnosis – Men billing 14.2% total revenue vs. Women 8.4%

10.4.2.1. # of services and total payments

10.4.2.2. Women annually billing around $10K and men around $21K

Discussion ensued on:

- Data provided doesn't allowed understanding of the discrepancy
- Is billing practice a factor?
- Duration of consult is a variable, suggest to look at data stratified by years of practice
- Single year of data is too limited data set

11. **ELECTIONS AND BYLAWS**

11.1. SGIMBC Bylaws: Bylaws were updated about 18 months ago, removed outdated terms (ex. telefax) and updating new election processes and Executive stipends.

It was MOVED and SECONDED

That the Society of General Internal Medicine Specialists of British Columbia accepts the updated bylaws.

CARRIED

11.2. Graham Lea has completed his term. The Executive thanks him for all his efforts.

11.3. Current SGIMBC Executive: Shavinder Gill, President; Jennifer Grace, Past President; Paul Hertz, Treasurer; Vacant, Secretary; Ritu Kumar, Member at large; Barry Kassen, Member at large; Danny Meyers, Economic Advisor; Samantha Segal, Member at large; Denise Jaworsky, Northern BC

11.4. Proposed SGIMBC Executive Members: Jasdeep Saluja, Vancouver Island; Casey Chan, Early Career, Terrence Yung, Member at large, Michael Pascas, Northern BC, Roopjeet Kahlon, Faraz Moein vaziri

It was MOVED and SECONDED

That the Society of General Internal Medicine Specialists of British Columbia accepts the following new members of the Executive Committee: Jasdeep Saluja, Casey Chan, Terrence Yung, Michael Pascas, Roopjeet Kahlon, Faraz Moein vaziri.

CARRIED

12. **2022 GIM LEADERSHIP AWARDS**

12.1. Noted two Career Leadership awardees for 2022, *Shahin Jaffer* and *Mark Ballard*. Congratulations to these excellent physicians who are making a great impact on their communities.

12.2. SGIMBC has developed additional awards to better recognize leaders across the GIM community: Early Leadership; Career Leadership; Equity, Diversity and Inclusion Champion, DoBC Committee.

12.3. All awards and details are listed on the SGIMBC website in the members-only section.

13. **COMMITTEES**

13.1. **EPAC** is the new disparity committee within Consultant Specialist of British Columbia (cSBC). No significant progress to date. Historically decisions favoured larger income groups. SGIMBC working on gathering data to advocate for more accurate remuneration. EPAC agreed that gender disparity would be managed individually per society/section.

13.2. **DoBC** - historically no GIM representation on DoBC committees or attendance at cSBC

13.2.1. Recently there have been a few GIM members who have been elected to various DoBC committees which will great benefit the GIM cause. Ex. One member elected to disparity committee representing medical sub-specialist groups.

13.2.2. GIM representation is critical on these committees so we have a voice at the table when important decisions are made that affect GIM.

13.3. **CSIM** has had many governance changes over the last few years. Important to liaise with all GIM societies and CSIM to advance GIM interests provincially and nationally.

13.4. **American College of Physicians (ACP)** largest IM society in the US. SGIMBC could work with and/or learn from them. Would suggest becoming a member then automatically become CSIM member. Publish excellent journal and MKSAP.

14. **PROVINCIAL ISSUES**

14.1. **Specialists Forum:** April 27, 2023 arranged by cSBC with DoBC. Strongly advise SGIMBC members to attend.

14.2. **Referral Process:** MSP sent letter to Tariff committee and DoBC noting they wanted to change the re-consultation time from 6 months to 1 year. cSBC is looking for input from all sections.

Discussion ensued on:

- cSBC requesting case stories/clinical scenarios on importance of 6-month re-consult being vital to patient care. Please send any examples to SGIMBC who will forward to cSBC.
- Noted the requirement for a new referral for a new consult after 6 months is NOT a new rule. Has always been listed in the preamble.
- Various re-referral scenarios in different communities and sections.

14.3. **Communication:** GIM lacking strongly used communication system. Website forum not being used much.

Discussion ensued on:

- Finding a spokesperson from each hospital/area who would liaise between GIM and local colleagues.
- Most effective electronic platforms for communication
- Needs to be simple, available to most people, something that people already use
- Potential sensitivity of topics being discussed online and security risks
- Potential security issues for personal information
- Proposal to start a committee to look into options (Facebook, Signal, Telegram, Slack, Discord, etc.)
- Members invited/noting interest – Salpy Kelian, Michele Dearden

14.4. **MRP role by GIM in Hospitals**

14.4.1. Increasing issue (ex. Fraser is short 30 Hospitalists) where GIM taking over patient primary care.

Discussion ensued on:

- Leveraging MRP need to increasing hospital follow up fee code (32308)
- Create Task Force with reps from Richmond, Burnaby, Abbotsford (Surrey ok with current APP)
- SGIMBC advocating at province-wide level, rather than individual health authority/hospital

14.5. GIM Physician Reviews/Audits

14.5.1. Physicians can be reviewed by MSP, a BC College or a Health Authority.

14.5.2. Tertiary care specialist was recently identified as reviewing a community internist.

14.5.3. Specialty may be determined by practice pattern for an MSP mini practice profile.

14.5.4. Not many GIM medical inspectors for audits so the next best option is then chosen.

14.5.4.1. Call to GIM physicians to apply to be auditors/medical inspectors. Paid position at sessional rates.

14.5.5. Audit appeals process via the "Billing Integrity Committee" or mediation.

Discussion ensued on:

- Changing to remedial process rather than punitive process.
- Need for an educational process on billing and documentation
- Standardization of document/billing across province

15. **NEW BUSINESS**: None.

16. **2023 AGM PLANNING:**

16.1. Dates: Fall/end of 2023

16.2. CME: Topics suggested – Billing, Disparity, EDI and Indigenous Cultural Safety, Section 3

17. ADJOURNMENT

There being no further business, the 2021 Annual General Meeting of the Society of General Internal Medicine Specialist of British Columbia concluded at 12:53 p.m.

Suggestions/Requests:

- Circulating KPMG report to members for review

- Proposal to start a committee to look into platform options (Facebook, Signal, Telegram, Slack, Discord, etc.). Members invited/noting interest were Salpy Kelian, Michele Dearden

- Creation of SGIMBC Data Working Group where interested members meet to start to discuss/develop proposals for funding and collaborators. Member time compensated by SGIMBC.

- Renegotiating/reducing banking fees

- Asking MSP regarding creation of an 'add-on modifier' with additional diagnostic codes.

Ex. See a patient for hypertension (32210) but also see them for obesity and sleep apnea. Could bill 'add-on modifier' code of $10-20 which could apply to 311 or 32210. Possible work around making codes provisional when changing them.

- how SGIMBC can support rural/remote working environments